If we understand the past we can plan for the future

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Tracing the history of prescribing in the UK and why it matters in present day dispensing

KEY EVENTS

The following historic events still affect prescribing in the NHS today:

- Lloyd George's introduction of an artificial split between doctors and pharmacists, which was not based upon a natural specialisation of tasks[2]
- The introduction of computers in the 1980s, which greatly affected prescribing within practices and led to new roles for pharmacists as pharmaceutical advisers[3]
- The introduction of Prescribing Analysis and CosT (PACT) data during the 1980s led to revolution in prescribing cost control, allowing pharmaceutical spending to be limited locally
- Prior to 1989, changes to the NHS were always based upon the evidence generated by a Royal Commission, but now policy advisers often lead the way[4]

In its modern form, prescribing is an act performed primarily by GPs and is the direct request for a named drug to be dispensed for a named patient. Although the art of suggesting and supplying medicines may be traced back to the most ancient of human civilisations, not until the introduction of the National Insurance Scheme (NIS) in 1913 did the modern practice of prescribing begin in the UK.[1]

For policy makers, advisers and academics, a knowledge of the history of prescribing could help explain how the current system of pharmaceutical provision has evolved and may lead to new policy thinking.

Understanding history

A better understanding of history may help illuminate many of the little understood aspects of prescribing policy that still have an important impact today. For example, how the Pharmaceutical Price Regulation Scheme (PPRS) has helped successive governments limit NHS spending on drugs;[5] and how the dispensing practice scheme has secured continuity of medicines supply to patients in areas without local pharmacies.[6]

Role of pharmacists

Currently, the NHS is exploring new roles for pharmacists, which is likely to result in more of them working within local practices. The search for new roles for this group has been a major feature of the policy landscape for many decades. For instance, the Nuffield Report recommended a number of measures that would reduce pharmacist involvement in dispensing and increase their activities elsewhere.[7]

The American concept of pharmaceutical Care, with its emphasis on re-professionalisation, became the blueprint for modern pharmacy in the NHS.[8] However, the national plan for pharmacy published in 2000 led to marginal changes only and did not radically shift the position of profession.[9] This is because pharmacists have been relentlessly campaigning for new roles when they should have been fighting to break down the medical, organisational and budgetary barriers that keep them locked out of primary care. By separating the dispenser from the prescriber, the NHS system for supplying drugs has created a professional cage for community pharmacists.

Misunderstanding the nature of the problem, the profession decided to focus on personal development rather than opting for wide-scale systems reform. Consequently, the pharmacists are now up-skilling and becoming knowledge workers, only to find that the antiquated design of the NHS gives few opportunities for individuals to prosper and to grow.

Information revolution

As every prescription passes from a prescriber to a dispenser and then is posted for coding and reimbursement nationally, the NHS is in an enviable position for creating "big data".[10] However, after the Second World War the sheer scale of prescriptions issued meant that the NHS was unable to efficiently process data on all of the medicines dispensed, with the consequence that relatively little evidence on prescribing patterns was available.

The problems continued when the Prescription Pricing Authority (PPA) took over the tasks of processing prescriptions, paying pharmacists and generating prescribing data.[11] In response, during the mid-1970s the Director of the Oxford Centre for Management Studies, Mr RI Tricker, was invited by the Department of Health and Social Security (DHSS) to undertake a fundamental inquiry into the PPA's functions, constitution and organisation.

In particular, he was asked to investigate the reasons for delays in reimbursing pharmacists and dispensing doctors, and to appraise the PPA's potential as a source of prescribing information. In March 1977, Mr Tricker reported that the PPA processed the bulk of prescription forms manually and that computerisation could help improve the processing and extend the range and regularity of prescribing information provided by the authority.

Cost control

Based upon Tricker's recommendations, the subsequent introduction of Prescribing Analysis and CosT (PACT) data during the 1980s led to revolution in prescribing cost control. Instead of relying on national initiatives such as the PPRS and the prescription charge, pharmaceutical spending could be limited locally. For instance, prescribing advisers were employed by local health authorities, local formularies were introduced, and medicines management became a new task for pharmacists.

Undoubtedly, PACT data provided a much needed innovation at the time, which produced a volume of quality of information almost unmatched worldwide. However, the strengths of the system also limited its usefulness in the long-term. For instance, basing data collection around items dispensed rather than patients meant that the PACT system could only make generalisations about the appropriateness of practice prescribing. Therefore, what was ground breaking in one era eventually led to a historical constraint on the ways in which drug costs could be managed. Indeed, the PACT system now has many limitations compared to the projects that could be undertaken today with modern big data methods.

Practice budgets

A major impact of the PACT system was the ability of the government to record practice spending on drugs. Since the establishment of the NHS, there had been regular calls for better management of practice drug spends through the setting of pharmaceutical budgets. However, the negative experience of medicine budgets under the NIS led many governments to shy away from the idea.

Not until Margaret Thatcher stopped the political practice of asking a Royal Commission to advise on health policy did the budget idea became policy in 1991 as part of the fundholding scheme. Interestingly, the thinking behind the policy was based on the ideas of the health economist, Professor Alan Maynard, who suggested an evaluation before use.[12]

Because the scheme had generated such political opposition, the Labour Party soon abolished fundholding when it came into power in 1997, but kept the associated prescribing budgets.

As it quickly disappeared, the scheme raised some interesting questions, which political pressures conspired to leave

unanswered.[13–15] For instance, do hard budgets control prescribing costs? Do different types of practices respond to prescribing incentives in different ways? Do different models of commissioning affect prescribing outcomes? As these examples suggest, prescribing policy in the NHS has many interwoven drivers, and often new initiatives appear before the existing state of affairs is properly understood.

History into action

If any lessons can be learnt from this series of articles, the first lesson is that "history matters". As this suggests, what we observe today is often the product of some previous, long forgotten accident and (sometimes) a rational decision.

From personal experience, often individuals without an understanding of the past make policy suggestions that fail to work in the present. In response, policy makers and policy advisers should understand that NHS prescribing policy is historically constrained.

In particular, the main constraints are: an outdated structure, the need to adopt big data initiatives, and old ways of controlling costs that now need a refresh. As this list suggests, the second lesson from this historical series is that "systems matter". When the NHS is compared to the NIS, we can see great similarities in drug costs management simply because they share a common prescribing/dispensing system.

Evolving for current needs

Therefore, historical constraints have created systems that now need evolving for current needs.

Finally, the third lesson is that history should guide our contemporary choices and actions. To coin a phrase, I will name this third lesson, "history into action". Instead of being passive readers of narratives about our past, we should all search for ways in which knowledge about historical events can help us make better choices today. For instance, the reasons for the outcomes we currently observe in medicines optimisation and pharmacy re-professionalisation may be to do with historical constraints.

In conclusion, if you believe that prescribing history matters, then it is time to put history into action by searching for new ways of organising prescribing and dispensing within the NHS.[16]

References

1. Baines D. From the NIS to the NHS via the Floating Sixpence. *Prescriber* 2013;24(19): 47–9.
2. Baines D. Pharmacists as dispensers and formation of the PPA. *Prescriber* 2014;25(1–2):33–4.
3. Baines, D. The information age and its effects on NHS prescribing decisions. *Prescriber* 2015;26(1–2):10–13.
4. Baines, D. Working for patients: NHS reform and drug budgets. *Prescriber* 2014;25(17): 20–3.
5. Baines, D. Drug budgets and the strengthening of the PPRS. *Prescriber* 2014;25(19): 40–2.
6. Baines DL, Tolley KH, Whynes DK. The costs of prescribing in dispensing practices. *J Clin Pharm Ther* 1996;21(5):343–48.
7. Baines, D. New Labour, new NHS, new-age pharmacy? *Prescriber* 2015; 26(8):32–3.
8. Baines, D. Pharmaceutical care: the blueprint for modern pharmacy. *Prescriber* 2014;25(13–16):14–16.
9. Baines, D. Opportunity for integration lost in creation of new roles. *Prescriber* 2015;26(11): 17–19.
10. Baines D. Big Data: not just a lot more data. *Prescriber* 2013;24(13–16):7–8.
11. Baines D. Recommendations from the Tricker and Clothier reports. *Prescriber* 2014;25(3)32–4.
12. Baines, D. Improvements suggested by Enthoven and Maynard. *Prescriber* 2014; 25(12):33–4.
13. Whynes DK, Baines DL, Tolley KH. Prescribing costs in general practice: the impact of hard budget constraints. *Applied Economics* 1997;29:393–99.
14. Baines DL, Whynes DK. Selection bias in GP fundholding. *Health Economics* 1996; 5:129–40.
15. Smith J, Regen E, Shapiro J, Baines D. National evaluation of general practitioner commissioning pilots: lessons for primary care groups. *BJGP* 2000; 50:469–72.
16. Baines D. Dispensing: it's time to let it go. *The Pharmaceutical Journal* 2015;294(7847): 113–4.

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